| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 005042 | A. BUILDING: _____ B. WING _____ | 08/03/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TERRE HAUTE REGIONAL HOSPITAL | 3901 S SEVENTH ST TERRE HAUTE, IN 47802 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>This visit is a State hospital complaint investigation.<br><br>Date of Survey: 08/03/2015<br><br>Facility Number: 005042<br><br>Complaint # IN00169859<br>Unsubstantiated; lack of sufficient evidence.<br><br>Terre Haute Regional Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules.<br><br>QA: cjl 09/03/15 | S 000 | | |